



Performance Report

Performance Period April 2004-June 2004

Introduction

This report presents fourth quarter of fiscal year 2004 (April - June 2004) findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). The information provided is based on the most current data available, and where possible is aggregated at both statewide and district or complex levels.

CAMHD tracks data in four major areas: Population, Service, Cost, and Performance Measures. Population information describes the demographic characteristics of the children and youth served by CAMHD. Service information is compiled regarding the type and amount of direct care services provided. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are tracked to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extents to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected

CAMHD continues to report on measures of interest to the Federal Courts regarding the sustainability of improvements that have been made in the children's mental health service system in Hawaii. These measures are:

- 1) CAMHD outcome and results components will be implemented (Benchmark 22),
- 2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26),
- 3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative...CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed),
- 4) Personnel and Vacancy Reporting,
- 5) Benchmarks that describe complex-based service testing, and
- 6) Complaints (no Benchmark attached, reporting requested by the Felix Monitoring Project).

Pursuant to the Stipulation for Step-down Plan and Termination of the Revised Consent Decree, this report also presents data by Family Guidance Center for numbers of children and youth served by CAMHD, percentage of care coordinator positions filled, and percentage of youth served who have a Coordinated Service Plan.

CAMHD performance measures are selected to align the work of the organization to achieve results in core areas of service provision and supporting infrastructure. In addition to what is presented in this report, additional performance measures are used to guide quality activities and gauge their progress in achieving the overall objectives of CAMHD. CAMHD has been tracking many of its measures since 2001 or earlier, which has allowed for trending of performance over time and broader evaluation of impact of change.

Use of Performance Data in CAMHD

CAMHD's Performance Management practices involve an extensive system for examining performance and using findings to inform decisions about services and adjustments to program implementation. Managers throughout CAMHD monitor statewide, regional and program specific trends against performance goals. Data is timely and sensitive enough to determine unit and staff as well as system-wide performance.

The majority of performance measures in CAMHD are managed through two arenas that each have distinct reporting structures. As the managed care organization providing intensive behavioral health services for Medicaid-eligible youth in Hawaii, CAMHD maintains an active quality assurance and improvement (QAI) program. Goals of the QAI program are achieved through a work plan that maintains improvement activities and measures for each objective that have designated accountability and timelines for data collection and reporting. CAMHD's nine quality management committees are involved in the selection of the measures, and report through the Performance Improvement Steering Committee. The quality management committee structure serves as a core component of CAMHD's health plan operations.

The CAMHD Central Office is the other arena the selects measures to guide operational quality and efficiency. The three major offices that make up the Central Office are Administrative Services, Performance Management and Clinical Services. Section managers from the offices are accountable for presenting their results to the Expanded Executive Management Team. The CAMHD Family Guidance Centers also maintain quality assurance committees and track measures relevant to improving services and operations for their local service areas.

Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through CAMHMIS. CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data reflect the fourth quarter of fiscal year 2004 (April 2004 - June 2004) for youth registered in the CAMHD Family Guidance Centers. In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,852 youth across the State, an increase of 118 from the previous reporting quarter (January 2004 - March 2004), or a 6% increase in the total population. There has been a slight increase in the population over the past three quarters. Since the same period last year (April 2003-June 2003) CAMHD has experienced a 3% increase in its registered population. A full discussion of the population trend over the last three years can be found in the [Child and Adolescent Mental Health Division Annual Evaluation Report, Fiscal Year 2003](#). The report can be found on the CAMHD website at <http://www.hawaii.gov/doh/camhd/>.

The numbers of youth registered at each of the Family Guidance Centers during the fourth quarter are displayed below. The numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. The largest population was served on the Big Island of Hawaii (HFGC), and the smallest received services through the Family Court Liaison Branch, which provides services primarily for incarcerated and detained youth.

Table 1. Population of Youth Registered by Family Guidance Center, FY2004, Quarter 4

COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
140	198	177	150	158	441	515	73

The total number of registered youth are described by four subgroups: (i) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (ii) youth who were in the process of having services arranged (new admissions), (iii) youth who received less intensive services through Mokihana on Kauai, and (iv) youth who were discharged at some time during the quarter. There was also a percentage of youth who received intensive case management services only. Of the total registered youth, 957 had services that were authorized within the quarter.

Of the registered population (1,852), 163 youth (8.8%) were newly registered (have not previously received services) in the fourth quarter of fiscal year 2004. This represents an increase of 13 new admissions from the third quarter. One hundred forty-seven (147) youth (7.9%) who had previously received services from CAMHD were reregistered, an increase from last quarter's readmissions of 121 youth. Further study of characteristics of youth returning for services may be warranted. CAMHD discharged a total of 259 youth during the quarter, or 14.0% of the registered population. This is an increase from last quarter's discharge of 112 youth (6.5% of the registered population).

Of the 957 youth who had services authorized in the quarter, 59 were new admissions (6.2%), 62 repeat admissions (6.5%) and 76 discharges (7.9%). It is important to note that because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth registered in the reporting quarter was 14.4 years with a range from 3 to 20 years. This statistic has remained stable over time. As displayed in Table 2, the majority of youth were male (67%), again a stable description of the population and typical of youth served in other mental health service systems nationally.

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	614	33%
Males	1,238	67%

The ethnicities of youth registered in the reporting quarter as displayed in Table 3. In the past, these data were reported for youth with services authorized. Ethnicity data for registered youth have historically very closely approximated data for youth with authorized services. Those with Mixed ethnicities represented the largest group (30.6%), followed by youth of Hawaiian ethnicity (22.6%). Caucasian made up the third largest ethnic group (20.2%), followed by Filipino (7.9%) and Japanese (4.2%). Ethnicity data was not available (no data entered) for 33.9% of youth registered.

Table 3. Ethnicity of Youth

Ethnicity	N	% of Available
African-American	29	2.4%
African, Other	2	0.2%
American Indian	1	0.1%
Asian, Other	9	0.7%
Caucasian, Other	247	20.2%
Chamorro	1	0.1%
Chinese	9	0.7%
Filipino	97	7.9%
Hawaiian	277	22.6%
Hispanic, Other	14	1.1%
Japanese	52	4.2%
Korean	5	0.4%
Micronesian	7	0.6%
Mixed	374	30.6%
Pacific Islander, Other	20	1.6%
Portuguese	33	2.7%
Puerto Rican	11	0.9%
Samoan	36	2.9%
Not Available	628	33.9%

Many youth who receive services through CAMHD are involved with other public child-serving agencies including the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 4). In the quarter, 10.7% were involved with DHS, 27.1% had a Family Court hearing during the quarter, and 7.9% were incarcerated at HYCF or detained at the Detention Home. A new category for reporting which began last quarter is the numbers and percentage of the CAMHD population who are determined to

Table 4. Agency Involvement

Agency Involvement	N	%
DHS	198	10.7%
Court	501	27.1%
Incarcerated/Detained	147	7.9%
SEBD	383	20.7%
Quest	680	36.7%

be eligible for services through the Serious Emotional and Behavioral Disturbance (SEBD) referral process. Designation of SEBD occurs through the Memorandum of Agreement (MOA) with the Med-QUEST Division, which allows any QUEST or Medicaid fee-for-services eligible youth who meet criteria for this designation to receive services through CAMHD. The referral process for youth with SEBD has been widely publicized to encourage easier access to needed behavioral health services for the population. In order to reduce stigma, and provide a family-friendly orientation to services, CAMHD has renamed its SEBD services to “Supporting Emotional and Behavioral Development.”

Youth who were eligible for services through determination of SEBD were 20.7% of the registered population. Overall, QUEST-eligible youth who received services in the quarter were 36.7% of the population. Some QUEST-eligible youth may not have been screened through the SEBD process, and are eligible by virtue of their educational or court-ordered status.

Table 5. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	798	43.1%
Attentional	754	40.7%
Mood	650	35.1%
Miscellaneous	397	21.4%
Anxiety	293	15.8%
Substance-Related	275	14.8%
Adjustment	184	9.9%
Mental Retardation	33	1.8%
Pervasive Developmental	23	1.2%
Multiple Diagnoses	1,247	67.3%
Ave. Number of Diagnoses	1.9	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 5). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with authorized services in the quarter were disruptive behavior disorders (43.1%), attentional disorders (40.7%), and mood disorders (35.1%). This diagnostic breakdown has been fairly consistent over time.

Those youth with miscellaneous diagnoses accounted for 21.4% of the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control and eating disorders.

Many youth in the population have co-occurring, or more than one diagnosis. In the reporting quarter 67.3% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (77.4%) with an average of 2.2 diagnoses per youth, showing that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. The co-occurring diagnoses category includes youth who have both behavioral/emotional disorders and are substance abusing.

In the quarter, youth with substance-related diagnoses represent 14.8% of the population. This statistic may not represent all youth with a substance-related impairment, or the

number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic is expected to underestimate the total number of youth experiencing a substance-related impairment.

Services

Tracking of utilization of the services within the CAMHD array allows for accurate accounting and data-driven planning and decision-making. Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. On the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (April 2004-June 2004). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served were authorized to receive services provided in the home and/or community, which consist of Intensive In-home services (45.9%) and Multisystemic Therapy (12.2%). The largest group of youth in an out-of-home setting received services in a Community-based Residential program (18.2%). Youth receiving treatment while in Therapeutic Family Homes accounted for 13.9% of those served, and Therapeutic Group Homes 9.9%. While the Hawaii service system strives to serve youth in the least restrictive environment, these data represent a trend of higher use of community-based residential services than lesser-restrictive residential services.

Table 6. Service Authorization Summary (April 1, 2004-June 30, 2004).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	7	7	0.4%	0.7%
Hospital Residential	20	33	1.8%	3.4%
Community High Risk	10	11	0.6%	1.1%
Community Residential	136	174	9.4%	18.2%
Therapeutic Group Home	78	95	5.1%	9.9%
Therapeutic Family Home	114	133	7.2%	13.9%
Respite Home	1	4	0.2%	0.4%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	83	117	6.3%	12.2%
Intensive In-Home	360	439	23.7%	45.9%
Flex	116	184	9.9%	19.2%
Respite	27	33	1.8%	3.4%
Less Intensive	43	102	5.5%	10.7%
Crisis Stabilization	5	12	0.6%	1.3%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

CAMHD is continuing to review recommendations targeted at assuring least-restrictive services including discussions with the Department of Education. Strategies under review include developing clear guidelines for level of care decision-making, continued focus on CASSP (Child and Adolescent Service System Principles) in supporting parents' role in treatment and care, focus on prevention of out-of-home placements, and more use of evidence-based interventions for youth with conduct issues.

In the reporting period, Flex services were provided for 19.2% of youth served. Flex services are a broad category that range from mental health services not provided through a regular purchase of service contract, to travel for youth in off-island residential programs, to interpretive services. They may also include purchase of assessments. Respite Home services continued to have relatively low utilization with only 3.4% of the served population receiving an authorization for this service in the reporting quarter, although trend data show an increasing percentage of youth have used this service over the past year.

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the third quarter of fiscal year 2004 (January 1-March 31, 2004). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 7. Out-of home residential treatment services in Hawaii, including hospital-based residential treatment, accounted for 83.8% of service expenditures. This compares to out-of home residential treatment services accounting for 83.3% of the total costs in the second quarter of FY 2004, or a .5% increase in percentage of total expenditures. Youth in out-of-state treatment settings accounted for only 1.5% of total expenditures.

Hospital-Based Residential Services experienced an increased cost of 2.8% in the reporting quarter. Additionally, there was a slight increase of .2% in the cost of Community-Based Residential Services. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth (\$47,236 per youth). For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes (\$15,963 per youth).

In-Home (Intensive In-Home and MST) and less intensive services accounted for 12.7% of the unduplicated cost of services, which is slightly lower than the last reporting quarter (January 2004-March 2004) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of

\$4,816 per youth (\$2,274 for those that Intensive In-Home service only, and no other services in other levels of care), which continues to be significantly less than the cost per any youth in a residential program.

Youth who received Flex services during the quarter had a cost of \$20,201 per youth, or a cost just in this level of care of \$838 per youth. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for flex services suggest that youth in out-of home placements account for a high percentage of youth receiving flex services.

Table 7. Cost of Services (January 2004-March 2004)

Any Receipt of Services	Total Cost (\$)	Cost per Youth (\$) ^a	Cost per LOC (\$) ^b	Cost per LOC per Youth (\$) ^b	% of LOC Total (\$) ^b
Out-of-State	150,175	25,029	149,971	24,995	1.5%
Hospital Residential	927,739	28,113	720,925	21,846	7.1%
Community High Risk	472,363	47,236	435,105	43,511	4.3%
Community Residential	4,492,887	24,960	4,022,415	22,347	39.8%
Therapeutic Group Home	1,990,385	23,695	1,678,782	19,986	16.6%
Therapeutic Family Home	1,995,402	15,963	1,616,711	12,934	16.0%
Respite Home	9,791	9,791	564	564	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	516,366	4,451	348,312	3,003	3.4%
Intensive In-Home	1,955,313	4,816	923,078	2,274	9.1%
Flex	3,636,178	20,201	150,809	838	1.5%
Respite	221,347	6,510	29,816	877	0.3%
Less Intensive	171,603	17,160	22,874	2,287	0.2%
Crisis Stabilization	69,882	7,765	18,708	2,079	0.2%

Note: ^a Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care. ^b Cost per LOC represents unduplicated cost for services at the specified level

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and Family Guidance Centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

Although the Memorandum of Agreement (MOA) between CAMHD and DDD ended in June 2004, the provision of services, supports and coordination for youth with mental retardation and developmental disabilities continued for the target population.

Respite Services

For April, May and June, DDD met respite needs of the target population through the DDD service system. DOH case managers continued with assisting families to access other service options such as DDD Respite (via open enrollment), Home and Community-Based Service—DD/MR (HCBS-DD/MR) waiver program, and other DDD funded supports. The table below shows updated utilization of various DDD services that families accessed to meet their needs.

Table 8. Other Service Options Utilized by CAMHD Respite Recipients

DDD Service	# of Users
*HCBS - DD/MR Waiver	46
**POS - Partnerships in Community Living (PICL)	5
***DDD Respite	53
Family Support Services Program (FSSP)	10

* Waiver admission as of 6/30/04

** There were no PICL referrals for period of 4/1/04 – 6/30/04

***DDD Respite (CAMHD recipients who applied for DDD Respite in June 2004)

Table 9. Expenditures to Date for CAMHD Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	\$146,775.18	45%	\$2,010.62
Hawaii	34	26%	\$89,564.00	27%	\$2,634.24
Kauai	11	8%	\$54,174.50	17%	\$4,924.95
Maui	14	11%	\$33,258.00	11%	\$2,589.86
Total Youth	132	Total Dollars Expended (July 2002-June 2004)			\$326,771.68

While families accessed DDD service options, minimal respite expenditures for the period April, May, and June occurred. The total dollars expended for the target population since July 2002 is \$326,771.68.

Residential Services

The Individual Community Residential Support (ICRS) contract was extended until June 30, 2005. There are currently four individuals, two adults and two youth, being served under the ICRS contract. The extension was necessary to transition three individuals from a special treatment facility setting to other licensed residential placements. In addition, one youth continued to receive psychiatric treatment and hospital-based residential services. To date, all but one out of the four individuals under the current contract have been admitted to the HCBS DD/MR waiver program. The youth who is not in waiver continued to receive psychiatric treatment and hospital-based residential services.

Two of the three individuals residing in the special treatment facility setting are now adults, and two potential adult foster homes have been identified for them. The mother of

the remaining youth in the special treatment facility will seek voluntary foster placement for her child.

DDD case management staff have met with the parents of the youth who continues in the hospital-based residential setting. Needs of the youth were identified for transition from the hospital-based residential setting to the community.

Out of the ten individuals reported in April 2004, six are no longer being served under the current ICRS contract for various reasons. All six individuals have been admitted to the HCBS DD/MR waiver program. Three of the six individuals are now adults in residential placements. One youth is in a CPS placement, and DHS has permanent custody. The remaining two youth live with a parent and aunt, respectively. All youth have been attending school regularly and have DDD case management services.

Performance Measures

CAMHD uses performance measures to demonstrate sustainability and adequacy of services, results, infrastructure, and key practice initiatives. They measure the ability to maintain gains made since the inception of the Felix Consent Decree, and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

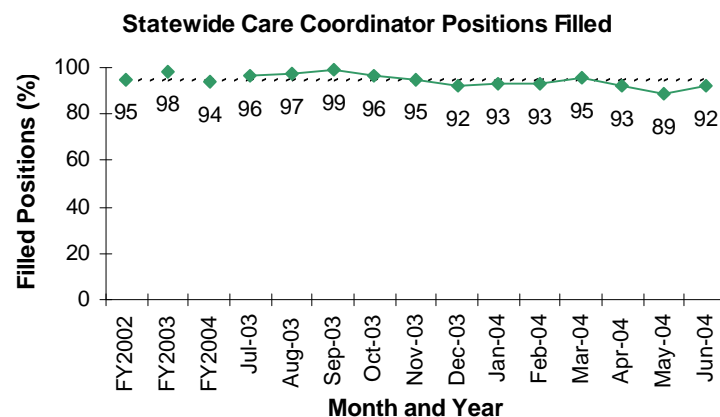
Those performance measures linked to previous Court Benchmarks are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇒ *95% of mental health care coordinator positions are filled**

Over the reporting period, CAMHD had an average of 91% of care coordinator positions statewide filled, which did not meet the performance goal. The quarter ended with CAMHD still slightly below the goal. This quarter's data reflects the third consecutive quarter the performance goal was not met since this indicator was reported at the start of FY 2002.



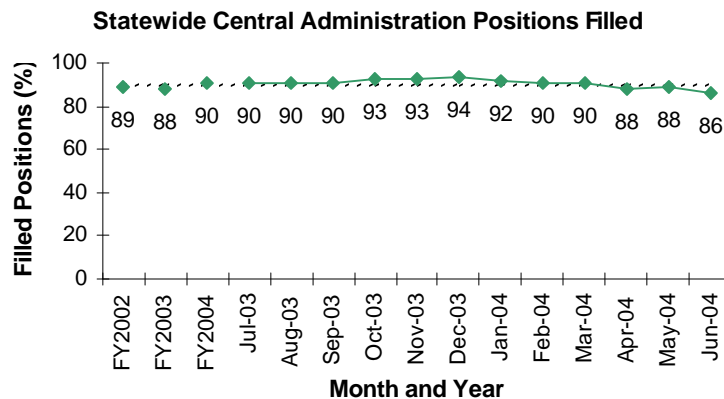
The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below. As can be seen, vacancies in Central Oahu, Leeward Oahu, the Big Island and Kauai impacted the Statewide average. Active recruitment is underway for all sites.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
88%	90%	100%	100%	100%	85%	90%

Goal:

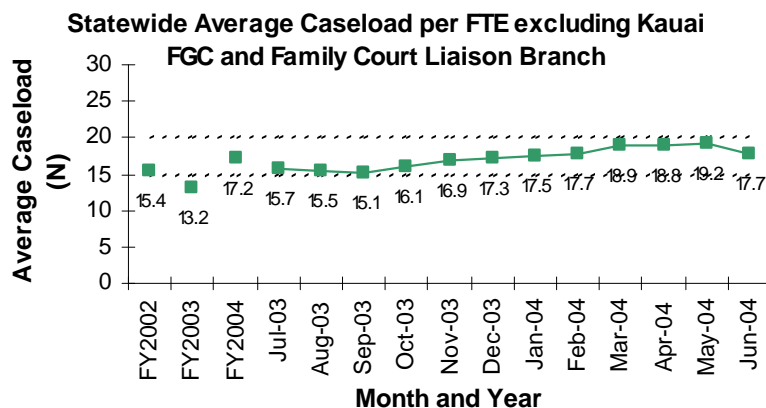
⇒ *90% of central administration positions are filled**

The performance target was not met as an average of 87% of central administration positions filled over the quarter, which is slightly below the goal. Central Administration positions provide the infrastructure and quality management functions necessary to manage the statewide service system. Several vacancies across the sections impacted this measure, and all under active recruitment.

**Goal:**

⇒ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

The average caseload for the fourth quarter was within the target range at 18.6 youth per full time care coordinator equivalent (FTE). Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services.



The average caseloads performance target was met for five of the FGCs. It was not met for Hawaii FGC. Vacancies impacted the average for the Big Island.

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
4 th Quarter Average	19	18	18	20	15	22

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇒ **Sustain within quarterly budget allocation.**

The reporting quarter for this performance measure is January - March 2004, which allowed for closing of the contracted agency billing cycle. The total variance from the budget for the second quarter was under projection by \$3,787,000. These projections include service dollars that have been or will be encumbered and/or expended in the remainder of the fiscal year. CAMHD continues its trend of sustaining below the budget allocation in the quarter. Sufficient funds were encumbered for all expected service costs. Expenditures in all categories were below budget. Service expenditures accounted for 89% of the variance.

Variance from Budget (in \$1,000's)

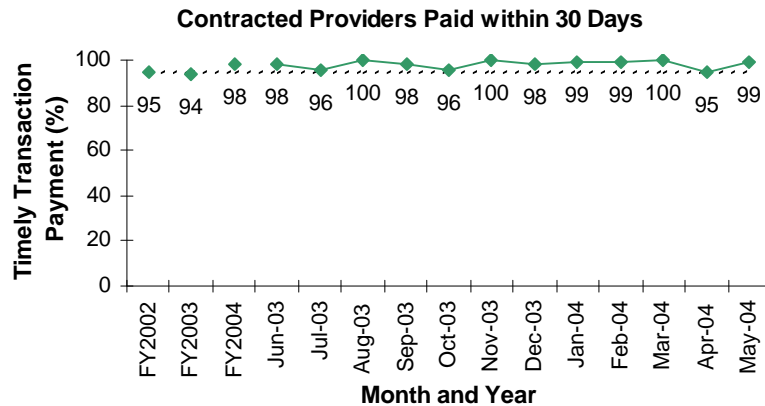
	FY 2002	FY 2003	FY 2004							
	Average	Average	Average	2003.1	2003.2	2003.3	2003.4	2004.1	2004.2	2004.3
Branch Total	\$164	-\$150	\$47	\$66	-\$195	-\$312	-\$162	\$134	\$62	-\$54
Services Total	\$798	-\$4,175	-\$2,431	\$315	\$2	-\$16,251	-\$5,941	\$59	-\$3,963	-\$3,389
Central Office Total	-\$189	-\$388	-\$289	-\$833	-\$216	-\$352	-\$151	-\$226	-\$298	-\$344
Grand Total	\$773	-\$4,713	-\$2,673	-\$452	-\$408	-\$16,915	-\$6,254	-\$33	-\$4,200	-\$3,787

CAMHD will maintain timely payment to provider agencies

Goal:

⇒ *95% of contracted providers are paid within 30 days*

The target goal was met for the quarter with an average of 97% of contracted providers paid within the 30-day target. This was a slight decline over last quarter's result of 99% paid within 30 days. As standard for reporting, data is only available for the months of April and May, as June's payments are in mid-cycle as of this report. April saw a slight dip in the high performance that had been experienced over the previous five months with 95% of providers paid within the desired time period, however performance improved in May.

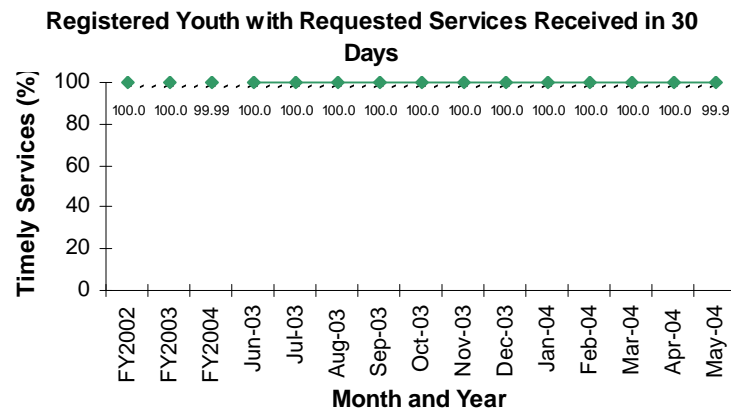


CAMHD will provide timely access to a full array of community-based services

Goal:

⇒ *98% of youth receive services within thirty days of request**

The goal was met for the quarter with 99.9% of youth provided timely access to services. This is the first time a service gap has been seen since August of 2001. As usual for reporting, data are only available for the first two months of the quarter, and the last month of the quarter's data will be reported in next quarter's report.

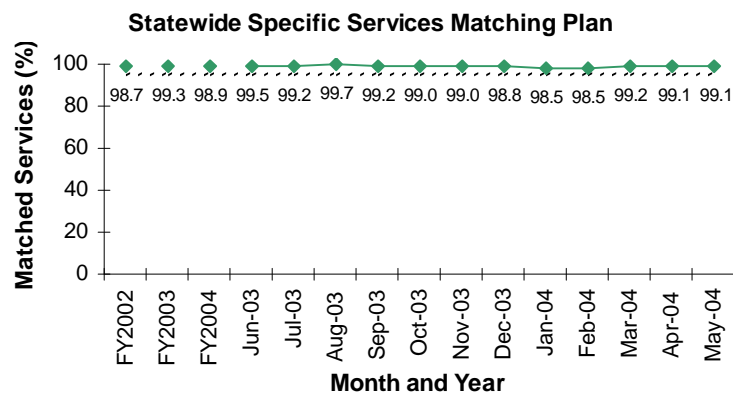


Goal:

- ⇒ 95% of youth receive the specific services identified by the educational team plan*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter 99.1% of youth received the specific services identified by their team plan. These youth received services within 30 days, but they were not the exact service selected by their service teams. As usual these data are for the first and second month of the reporting quarter as third month data are not available at the time of publication.

In the fourth quarter, service mismatches occurred in sixteen complexes versus eighteen in the previous quarter. Hilo continued to have mismatches for six youth. All of the Hilo youth had juvenile court-related issues impacting the implementation of their service plans. Kea'au Complex, which had 5 mismatches last quarter, had only one mismatch this quarter.



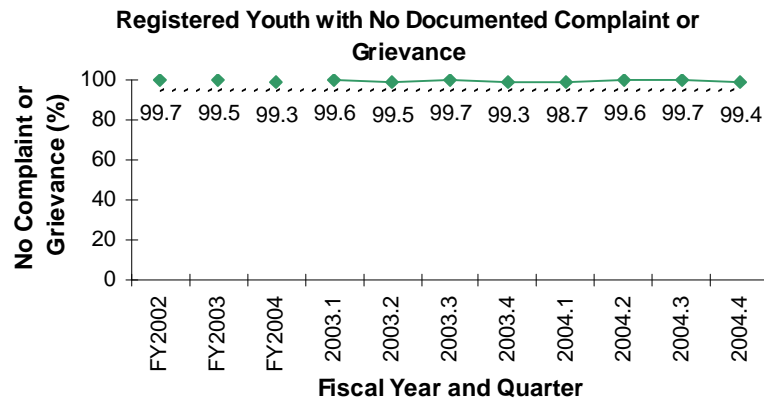
The remaining complexes experiencing mismatches had two or less. Baldwin Complex, which had struggled in the past with adequate capacity of intensive in-home services, had no mismatches in the quarter.

*CAMHD will
timely and
effectively
respond to
stakeholders'
concerns*

Goal:

⇒ 95% of youth served have no documented complaint received*

99.4% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers.

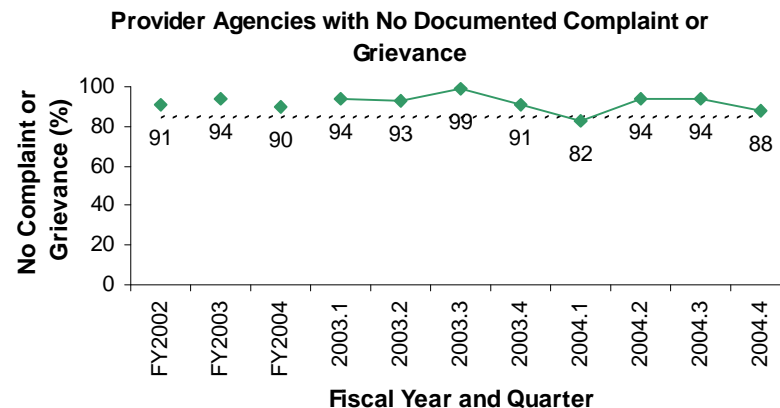


In the quarter, there were 12 youth with documented complaints representing 12 complexes statewide. This compares to 5 youth with documented complaints representing 4 complexes last quarter. There were two complaints for youth who were part of the King Kekaulike Complex; the remainder of complexes had one complaint each (Aiea, Mililani, Kalaheo, Campbell, Kapolei, Waipahu, Kalani, Kea'au, Kealakehe and Kauai High). There are no noticeable trends in the data.

Goal:

⇒ 85% of provider agencies have no documented complaint received

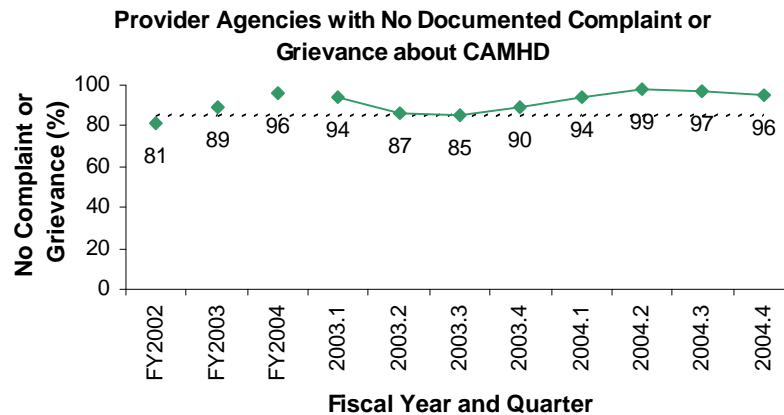
88% of provider agencies had no documented complaint about their services, which met the performance goal. This is a decline in performance since the last quarter.



Goal:

- ⇒ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 96% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY2003. CAMHD has implemented a Provider Satisfaction Survey, which allows for focused feedback from provider agencies about the performance of the various sections within CAMHD.

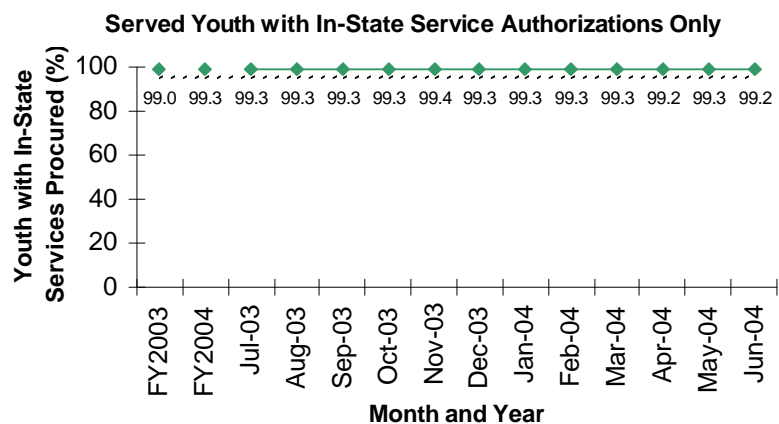


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

- ⇒ 95% of youth receive treatment within the State of Hawaii*

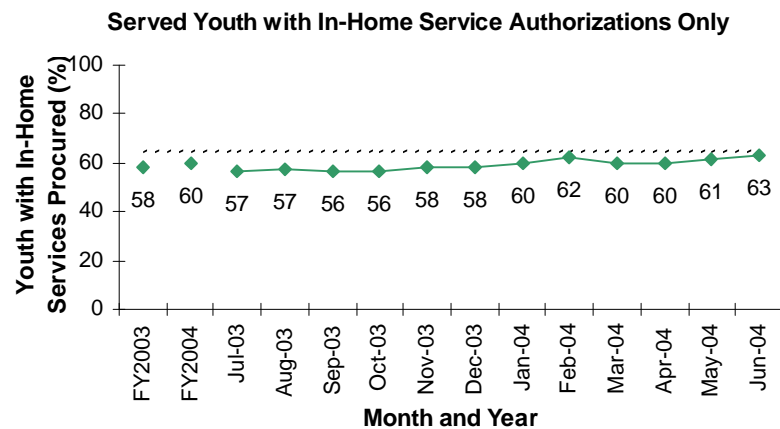
In the quarter, an average of 99.2% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Seven youth received services in out-of state treatment settings in the quarter, one more than last quarter. These data represent youth registered in CAMHD, and not all youth from Hawaii who were in out-of-state treatment settings in the reporting quarter.



Goal:

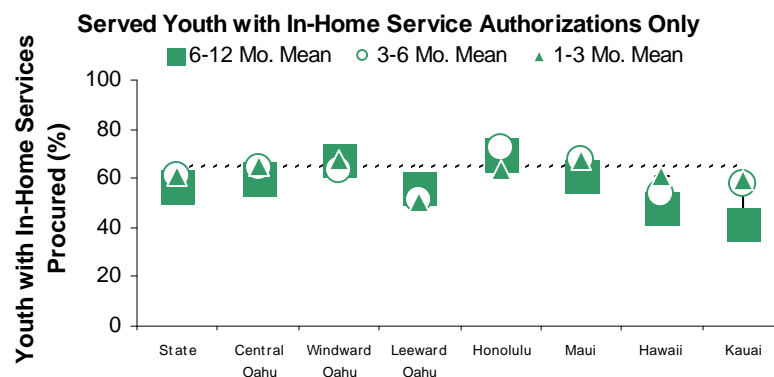
- ⇒ 65% of youth are able to receive treatment while living in their home

The quarter's data showed that an average of 61.3% of youth were served in their home communities throughout the quarter, which was short of the performance goal of 65%, but slightly above the performance of last quarter. The quarter ended with 63% of youth served while living at home, which is only 2% below the targeted goal, and the best performance CAMHD has seen since the establishment of this measure. The baseline year, 2003 saw only 58% of youth served in their homes.



The graph above displays slightly different data than past reports as it has been adjusted to include youth receiving case management services which more accurately reflects the numbers of CAMHD youth receiving treatment while living at home; prior reporting did not include this population.

There continues to be variable performance across the Family Guidance Centers on this measure. The goal was met for Central Oahu FGC (65.3% served in their homes), Windward Oahu (69.1% served in-home), Honolulu FGC (65.8% served in-home) and Maui FGC (70.8% served in-home) and nearly met for Hawaii FGC (64.3% served in-home).

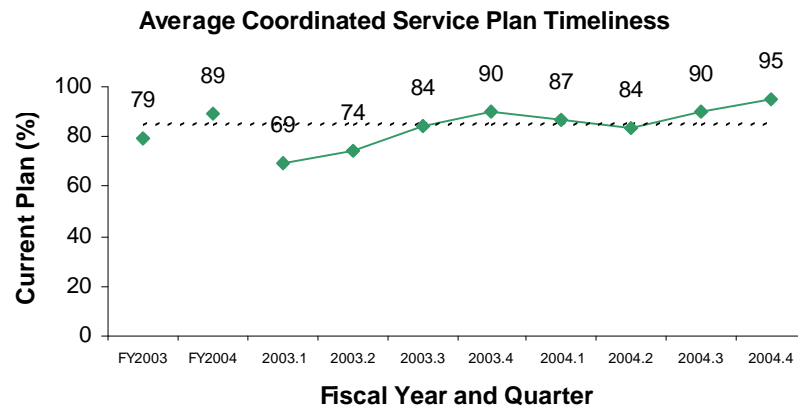


CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇒ **85% of youth have a current Coordinated Service Plan (CSP)***

CAMHD's performance in this measure met the performance goal for the reporting quarter with 95% of youth across the state having a current CSP. This represents the strongest performance for the State since this performance measure was established in 2002. All Family Guidance Centers met the performance goal in the reporting period.

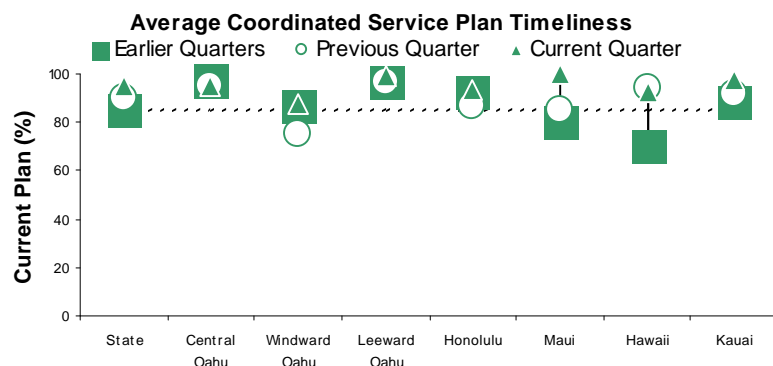


“Current” is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Average CSP Timeliness by Family Guidance Center

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KFGC
95	99	100	88	93	93	97

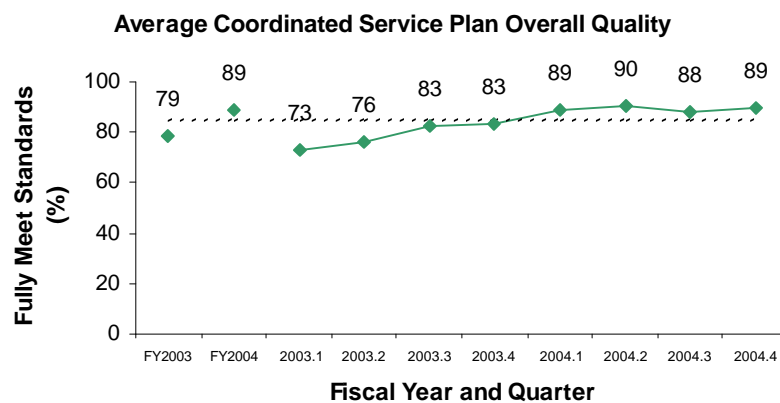
As previously cited and seen above the timeliness goal was met for all of the Family Guidance Centers. Trend data for each FGC are displayed below. As can be seen, timeliness improved for Windward, Leeward, Honolulu, Maui and Kauai.



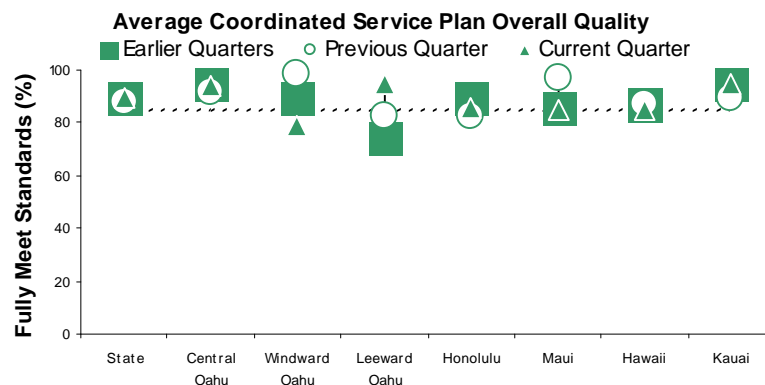
Goal:

- ⇒ **85% of Coordinated Service Plan review indicators meet quality standards***

The goal for this measure was met in the reporting quarter with 89% of CSPs sampled meeting overall standards for quality. Quarterly reviews of CSPs against standards for effective plans are a part of quality monitoring within each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures. The statewide data for quality of CSPs are displayed below:



The goal was met or exceeded by all FGCs with the exception of Windward. Maui experienced a decline in the quality of their plans. However, Leeward's CSP quality has improved substantially over the fiscal year. CSP quality is supported by training and consultation through the CAMHD Practice Development Section. These data are systematically referred to this section and also reviewed by the FGC quality assurance committees.



Mental Health Services will be provided by an array of quality provider agencies

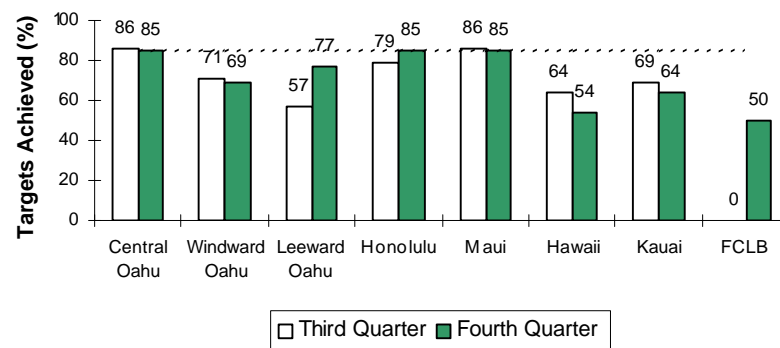
Goal:

- ⇒ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: expenditures within budget, grievances, access to services (service gaps/mismatches, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting at least 85% of the performance indicators was met by Central Oahu, Honolulu and Maui FGCs. On average across all FGCs, 71% of all goals were met in the quarter, compared to 64% in the last quarter. The Family Guidance Centers generally did well in indicators of adequate caseloads, timely access, response to concerns, serving youth in the State, and youth showing improvements as measured by the CAFAS or ASEBA.

FGC Performance Indicators Successfully Achieved

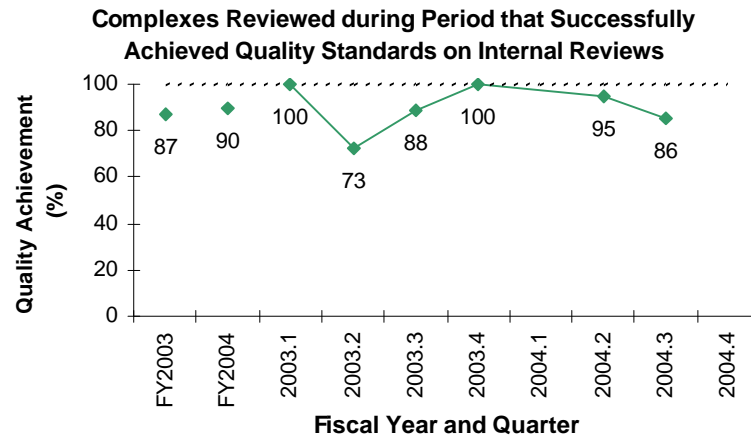


Any performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. The FGC management team tracks the implementation of each improvement strategy.

Goal:

- ⇒ 100% of complexes will maintain acceptable scoring on internal reviews*

No complexes were reviewed in the reporting quarter. Internal Reviews will resume in the Fall. As seen below, overall performance in Internal Reviews improved this year. In the year, four complexes did not meet their goal of achieving acceptable results in System Performance for 85% of youth reviewed. The complexes have all developed targeted improvement plans and have received technical assistance from State offices.

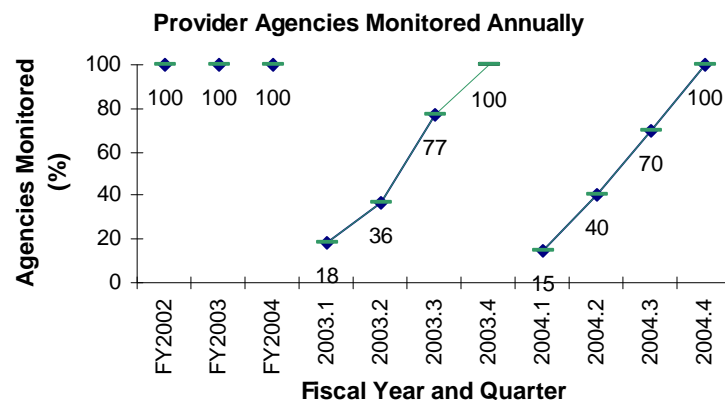


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇒ 100% of provider agencies are monitored annually

In the quarter, 100% of all agencies contracted to provide direct mental health services were monitored as scheduled, which also completes the annual goal. The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Nine agencies, representing fourteen contracts and six levels of care were monitored in the fourth quarter.

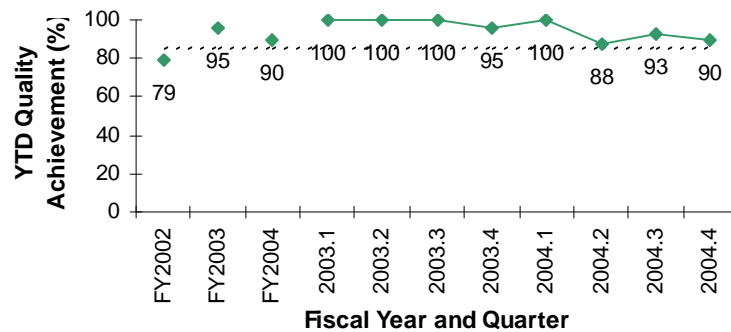


Goal:

⇒ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 90% of the provider agencies reviewed was determined to be performing at an acceptable level, which meets the goal for this measure. Provider agencies are reviewed across multiple dimensions of quality and effective practices. In the fiscal year, 90% of the agencies reviewed have been found to be performing at an acceptable level. Those agencies experiencing problems in meeting performance standards undergo focused corrective actions and technical assistance from CAMHD. Corrective actions are monitored for implementation and impact on changes in practice.

Provider Agencies Performing at an Acceptable Level

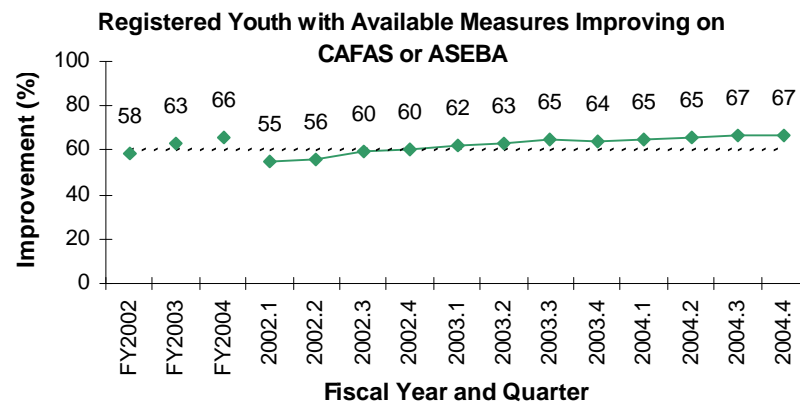


CAMHD will demonstrate improvements in child status

Goal:

⇒ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to complete the CAFAS and Achenbach (ASEBA) for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.

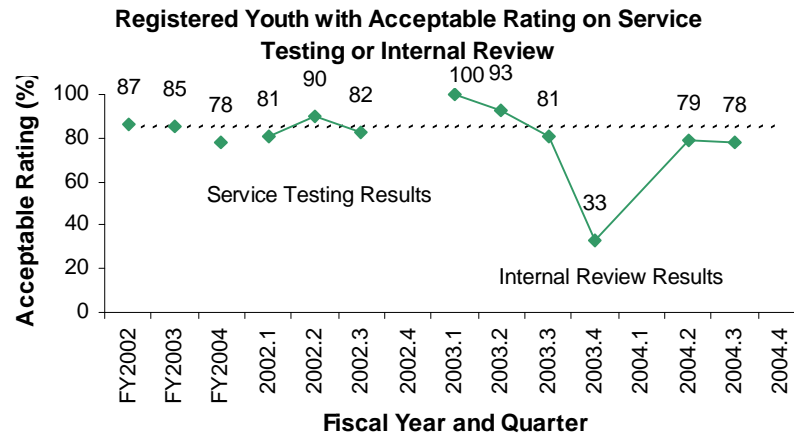


In the reporting quarter, for youth with data for these measures, 67% were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a steady upward but stabilizing trend in functional improvements for youth served by CAMHD. Child functioning as measured by these scales has improved by 9% since the end of FY 2002.

Goal:

- ⇒ 85% of those with case-based reviews show acceptable child status

No Internal Reviews were conducted in the quarter.



Families will be engaged as partners in the planning process

Goal:

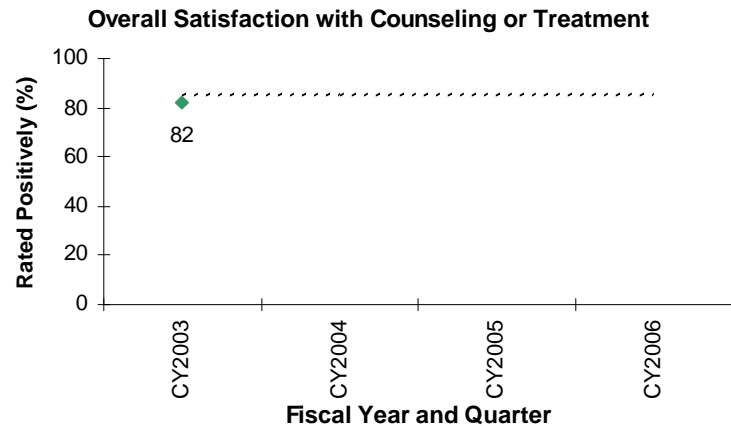
- ⇒ 85% of families surveyed report satisfaction with CAMHD services

In Spring of 2004, CAMHD initiated its annual administration of the Experience of Care and Health Outcomes (ECHO™) survey. The survey was selected because it builds on widely used instruments for behavioral health care quality assessment, and was designed with the unique needs of populations similar to that served by CAMHD. It assesses consumer experiences with a number of aspects of care including quick access to care, communication with clinicians, information provided by clinicians, consumer involvement in treatment, information about treatment options, and the behavioral health organization's administrative services. The survey collects useful information about the characteristics of youth and their families. Satisfaction and consumer experiences with services are important for mental health delivery systems to understand in working toward optimal care and outcomes. The comprehensive report of this year's survey results (assessing satisfaction for calendar year 2003) can be found on the CAMHD website at <http://www.hawaii.gov/health/mental-health/camhd/index.html>.

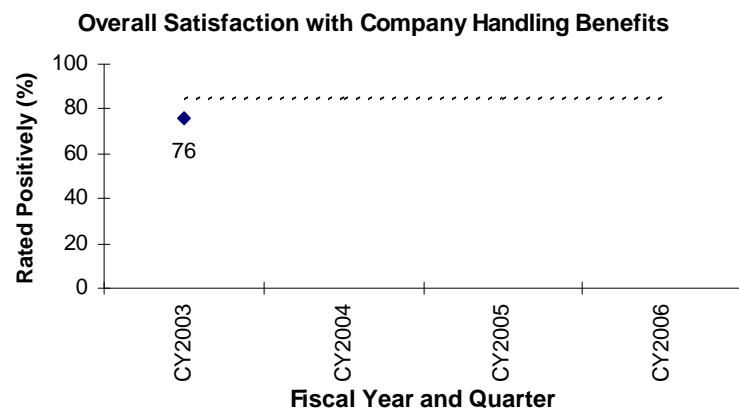
Another advantage of using the ECHO™ survey is that it allows for comparison of CAMHD results with other children's mental health delivery systems. Each fall, data from all the behavioral health plans across the country that use the ECHO™ are released, and CAMHD will be able to use this information to further refine its benchmarks on the indicators selected to measure quality.

Results regarding two aspects of overall satisfaction are presented below. The survey found that 82% of CAMHD caregivers were satisfied overall with their child's counseling or treatment. This

provides baseline data for this measure, and is just below targeted performance. These data will help CAMHD identify any needed improvements on this indicator.



Another key measure of satisfaction falls under the title of “Overall Satisfaction with the Company Handling Benefits.” This question allowed respondents to rate their overall satisfaction with CAMHD’s management of their child’s behavioral health care. Results for this indicator fell below targeted performance with 76% of those surveyed satisfied with CAMHD’s handling of their child’s care. The detailed analysis provided in the survey will help CAMHD identify specific improvements in managing care for consumers.



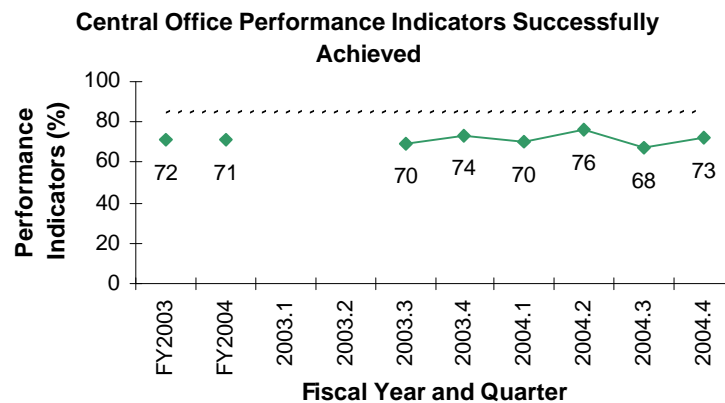
There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇒ 85% of CAMHD Central Office performance measures will be met.

CAMHD’s Central Administrative Offices utilize performance measures for each section as accountability and planning tools. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 37 measures currently tracked by EEMT.

In the fourth quarter, 73% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator, but an improvement over last quarter’s performance. The measures that fell below expectations continued to be impacted by staff vacancies.



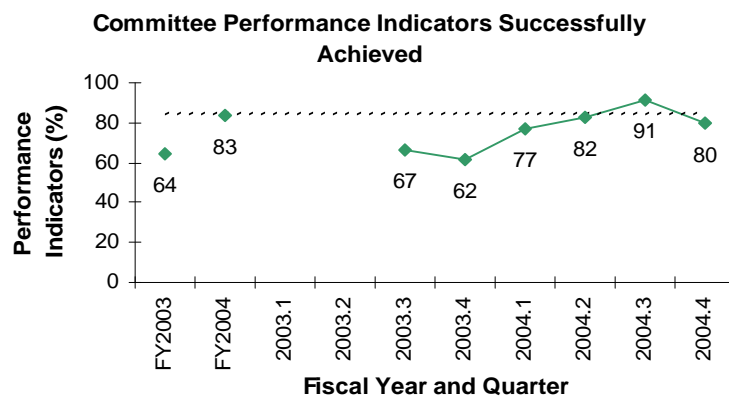
Improvements to impact Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

- ⇒ **85% of CAMHD State Committees performance measures will be met.**

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of thirteen measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter 80% of performance measures were met through the work of the CAMHD Committees, which does not meet the goal for this quality indicator, and is a decline over last quarter's performance. Focused improvement initiatives have had a major impact on improved performance.



Summary

The majority of performance goals were met or exceeded in the fourth quarter. The asterisked measures are those linked to historical Federal Court benchmarks. Of these “sustainability measures”, all indicators fully met the performance goal in the reporting quarter except for filled care coordinator positions, which was 4% below targeted performance. Several of the non-core measures were also below benchmark. The areas of strength were funding, timely access to services, system responsiveness to stakeholder concerns, serving youth within the State, timely and quality service plans, and quality service provision.

The following were measures that met or exceeded goals:

- Filled central office positions*
- Care coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Youth receiving services within 30 days of request*
- Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:*

 - Youth with no documented complaint received
 - Provider agencies with no documented complaint received
 - Provider agencies with no documented complaint about CAMHD performance

- Youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*

The following measures demonstrated a stable or improving trend, but did not achieve the targeted goal:

- Filled Care Coordinator positions*
- Youth receiving treatment while living in their homes
- Central Office performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies as discussed in the body of this report:

- State Committees performance indicators
- Family Guidance Center performance indicators

Family Satisfaction data was presented as a baseline measure that will be reported on annually. These measures did not meet the established performance goal. The survey was recently received by CAMHD. Results are scheduled to be presented to the Performance Improvement Steering Committee in August, who will recommend any needed improvements to CAMHD’s program based on findings of the study.

- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits

There were no Internal Reviews conducted in the quarter, and thus no available data for the following measures:

- Child Status as measured by Internal Review Results
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*

The reporting period extended the trend experienced by CAMHD over the past several years in demonstrating stable services and service-delivery infrastructure. The State Committees' measures that did not meet performance targets are under active management by the Performance Improvement Steering Committee (PISC) and the Expanded Executive Management Team. Factors impacting performance include vacancies, management of timelines, and workload distribution issues. Family Guidance Center quality measures that need improvement are addressed through the FGC quality assurance committees, CAMHD supervision structure, and are part of the PISC agenda. CAMHD is refining the analysis afforded through quarterly and annual monitoring of the FGCs to improve performance in areas that are not meeting objectives.